This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.kp.org/plandocuments** or by calling **800-777-7902**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See Chart on Page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	**No**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes**. For **Plan Provider** **$6,350** person / **$12,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges (unless balance-billing is prohibited), and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No**.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes**. For a list of **preferred providers**, see **www.kp.org** or call **800-777-7902**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**Yes**. You may self refer to certain specialists.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	**Yes**.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	Not Covered	Copayment waived for children under age 5.
	Specialist visit	$40/visit	Not Covered	————————none————————
	Other practitioner office visit	$40/visit	Not Covered	Chiro limited to 20 visits per condition per year.
	Preventive care/screening/ immunization	No Charge	Not Covered	Cost-sharing will apply if non-preventive services are provided during a scheduled preventive visit.
If you have a test	Diagnostic test (x-ray, blood work)	$20/visit	Not Covered	————————none————————
	Imaging (CT/PET scans, MRIs)	$250/test	Not Covered	————————none————————

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary .	Generic drugs	$10/prescription	Not Covered	Copay for up to 30-day supply. Up to 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Preferred brand drugs	$30/prescription	Not Covered	Copay for up to 30-day supply. Up to 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Non-preferred brand drugs	$50/prescription	Not Covered	Copay for up to 30-day supply. Up to 90-day supply for 2 copays. No charge for preventive drugs, contraceptives or oral chemotherapy drugs.
	Specialty drugs	$150/prescription	Not Covered	Copay for up to 30-day supply. Up to 90-day supply for 2 copays. No charge for oral chemotherapy drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	Not Covered	——————none——————
	Physician/surgeon fees	30% Coinsurance	Not Covered	——————none——————
If you need immediate medical attention	Emergency room services	$250/visit	$250/visit	Copay waived if admitted
	Emergency medical transportation	No Charge	No Charge	Non-licensed ambulance services not covered
	Urgent care	$40/visit	$40/visit	Non-plan providers are covered only outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500/day	Not Covered	Copay per day for 4 days; no charge after day 4.
	Physician/surgeon fee	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/visit	Not Covered	Group Therapy is $10/visit.
	Mental/Behavioral health inpatient services	$500/day	Not Covered	Copay per day for 4 days; no charge after day 4.
	Substance use disorder outpatient services	$20/visit	Not Covered	Group Therapy is $10/visit.
	Substance use disorder inpatient services	$500/day	Not Covered	Copay per day for 4 days; no charge after day 4.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Cost sharing applies for non-routine obstetrical care.
	Delivery and all inpatient services	$500/day	Not Covered	Copay per day for 4 days; no charge after day 4.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	——————none——————
	Rehabilitation services	Inpatient: $500/day; Outpatient: $20/visit	Not Covered	Inpatient: Copay per day for 4 days; no charge after day 4; Outpatient: PT/OT/ST limit of 30 visits/therapy/condition/yr. Cardiac Rehab limit of 90 visits/therapy/yr. Pulmonary Rehab limit of 1 program/ lifetime.
	Habilitation services	$20/visit	Not Covered	Limit of 30 visits for adults age 19 and over per year.
	Skilled nursing care	$250/admission	Not Covered	Limited to 100 days per year.
	Durable medical equipment	30% Coinsurance	Not Covered	——————none——————
	Hospice service	30% Coinsurance	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	$20/visit	Not Covered	One exam per year.
	Glasses	No Charge	Not Covered	1 pair glasses/yr (single OR bifocal lenses) OR 1st purchase of contact lenses/yr OR 2 pair/eye/yr medically necessary contacts (select group of frames and contacts)
	Dental check-up	No Charge	Not Covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per yr; 2 bitewing x-rays per yr, 1 set full mouth x-rays every 3 yrs.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care with limits
- Hearing Aids with limits
- Infertility Treatment
- Routine Dental Services (Adult) with limits
- Routine Eye Exam (Adult)
- Routine Hearing Tests
- Voluntary Termination of Pregnancy with limits

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 800-777-7902. You may also contact your state insurance department at 1-800-492-6116.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-866-444-3272

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 800-777-7902 or TTY/TDD 1-301-879-6380 or 711.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-777-7902 or TTY/TDD 1-301-879-6380 or 711.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 800-777-7902 or TTY/TDD 1-301-879-6380 or 711.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-777-7902 or TTY/TDD 1-301-879-6380 or 711.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,840
- **Patient pays** $700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$0
Copays	$500
Coinsurance	$0
Limits or exclusions	$200
Total	**$700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,220
- **Patient pays** $1,180

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$0
Copays	$700
Coinsurance	$400
Limits or exclusions	$80
Total	**$1,180**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 800-777-7902, TTY/TDD 1-301-879-6380 or 711.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.